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IPRS

Integrated Payment and Reporting System

835 Reporting Specifications

Version 1.9

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January 2007

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Electronic Remittance Advice- 835 Transaction Set

The Electronic Remittance Advice (ERA ASC X12N 835) is a computer-generated document which provides the billing provider specific remittance advice information of all claims submitted to MMIS+, along with a detailed breakdown of payment. The ERA is produced and transmitted to the billing provider upon completion of the Medicaid and IPRS claims processing cycles at the same time that checks or electronic funds transfers are generated.

Claims Filing - Overview of User Tasks

The Integrated Payment and Reporting System (IPRS) is a claims processing system that will pay Division of MH/DD/SA (DMH) funds for claims submitted by billing providers enrolled in IPRS. The IPRS replaces volume of service reporting for Pioneer, At-Risk Children and MRMI UCR systems. The Medicaid Management Information System (MMIS) is a claims processing system that pays Division of Medical Assistance (DMA) funds for claims submitted by billing providers enrolled in MMIS. IPRS together with the MMIS comprise the MMIS+.

Area programs are enrolled as billing providers in both IPRS and MMIS. Claims are sent by area programs to the MMIS+ in the same format for both IPRS and MMIS. The MMIS+ system determines the 'best payer' based on information on the claim.

EDS is the fiscal agent that operates the MMIS+. Claims are submitted to EDS for processing.

Below is the process used to submit claims to MMIS+:

Enter billable activity into local client accounting system.

Each billing provider enters records of services provided in their local client accounting system. The local client accounting system stores the service activity records, and submits billable activities to 'Payers'. Medicaid and DMH are designated as payers in the local client accounting systems.

New claims are submitted to MMIS+ in an electronic format.

The local client accounting system stores and submits a group (batch) of claims. For MMIS+, claims are submitted in an Electronic Format that is consistent with a national standard called ANSI X12N 837. This is the standard required by HIPAA. The client accounting system generates a file in the 837 format, and the computer administrator transmits that file to an EDS electronic mailbox. Claims can be submitted daily.

Review the Electronic Acknowledgement for files submitted electronically.

After an 837 file is transmitted to the EDS mailbox, two files will be generated to acknowledge the receipt of the transactions and report certain types of problems in the transaction set. These files should be reviewed by the sender.

Adjustment claims, and Medicaid claims with Third Party Liability, are mailed to EDS.

Certain types of claim activity must be done using hard copy claims and attachments. This includes adjustment claims, and Medicaid claims when the recipient has other third party coverage.

On Fridays, the MMIS+ performs claims payment processing (a "Checkwrite cycle").

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Generally, checkwrite cycles are run the 1st, 2nd and 3rd Fridays of each month. A schedule is published annually and distributed to billing providers. Claims that were submitted since the previous checkwrite cycle are routed to the best payer, assigned an Internal Claim Number (ICN) and processed. Some claims that were partially processed during previous cycles may also be re-processed, such as suspended claims, deny-re-enter claims, and system generated claims for retroactive Medicaid eligibility or retroactive rate revisions.

Download the Electronic Remittance Advice files.

After each checkwrite cycle, billing providers must access their EDS electronic mailbox and download the Electronic Remittance Advice files. There will be two different files. The first is the Remittance Advice in ANSI X12N 835 format that contains information on paid and denied claims and the second is the ANSI X12N 277 format that contains information on suspended claims.

Use local software to process remittance files.

Your local system must have software to view and print the electronic RA. Your local software may provide you with the capability to post paid claims to your client accounting system.

An Electronic Remittance Advice Financial Summary will be produced.

This will report the payment amount, as well as any uncollected receivable amounts (debt).

An Electronic Funds Transfer will be made to the billing provider.

The fiscal agent will transfer payments for both DMA and DMH in separate funds transfers.

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835 Business Use and Definition

The ASC X12N 835 is intended to meet the particular needs of the health care industry for the payment of claims and transfer of remittance information. The 835 can be used to make a payment and send an Explanation of Benefits (EOB) remittance advice from a health care payer to a health care provider.

Payment

Note ☞ *In all instances, "payee" refers to the billing providers. Likewise, "payer" refers to the actual payer, DMH or DMA.*

The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. One 835 transaction set reflects a single payment device. In other words, one 835 corresponds to one check or one EFT payment. Multiple claims can be referenced within one 835.

Data Use

The 835 is divided into three levels, or tables.

- The Header level, Table 1, contains general payment information, such as amount, payee, payer, trace number, and payment method.
- The Detail level, Table 2, contains the Explanation of Benefits (EOB) information related to adjudicated claims and services.
- The Summary level, Table 3, contains the Provider Level Adjustment Segment, PLB, which provides information related to adjustments to the payment amount not specific to Table 2 claims. These adjustments can either increase or decrease the actual payment with respect to the Table 2 claim charges.

Note ☞ *The 835 is used to transmit payment and data needed for posting by a provider subsequent to the adjudication of a claim. Non-adjudicated claim information is carried in the ASC X12N Health Care Claim Status Notification Transaction Set (277).*

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*835 Transaction Summary

Loop/Segment	Comment
A. TRANSMISSION HEADER	
ISA Interchange Control Header	Repeated 1 time per transaction set
GS Functional Group Header	
ST TRANSACTION SET HEADER	
BPR Beginning Segment for Payment Order/Remittance Advice	
TRN Reassociation Trace Number	
Receiver Identification (Situational)	Clearing House Identification Segment – Medicaid Only
Production Date	
Loop 1000A – Payer Identification	
Payer Address	Address information will differ between DMA and DMH
Loop 1000B Payee Identification	
Payee Address	
Payee, City, State, Zip Code	
Payee Additional Identification	
B. SUBMITTED BILLING PROVIDER	
Loop 2000 - Submitted Billing Provider- Repeated for "subsidiary providers" multiple billing provider numbers or NPIs associated with same base billing provider	Repeat for each different billing provider or billing provider NPI for the same base billing provider in the 835 transaction set, incrementing LX count for each additional billing provider or billing provider NPI. (Example- Claims are processed for providers with different alpha suffixes, but the same base provider number)
Provider Summary Information	Submitted Billing Provider ID Transaction Statistics
C. CLAIM PAYMENT INFORMATION	
Loop 2100 - Claim Payment Information (Header Claim)	Repeat for each Claim for Submitted Billing Provider or billing provider NPI in Loop 2000.
CAS- Header Claim Adjustment (Situational)	Created only when the sum of the details is not equal to the Header Billed amount
Patient Name	Repeat once for each Claim in Loop 2000.
Service Provider Name	Situational
Corrected Priority Payer (Situational)	Medicaid Only

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Loop/Segment	Comment
Outpatient Adjudication Information (Situational)	Medicaid Only
Other Claim Related Identification Claim Payment Information	1st Occurrence – Medical Record Number 2nd Occurrence – CNDS Base ID for client
Claim Date (From)	
Claim Date (To)	
Claim Supplemental Information Quantity – (Situational)	**NO LONGER PRESENT UNDER HIPAA COMPLIANCY**
D. SERVICE PAYMENT INFORMATION	
Loop 2110 – Service payment information	Repeats for each service detail on the claim in Loop 2000.
Service Date-From	
Service Date-To	
CAS Service Adjustment (Situational)	Repeat for each service level adjustment for Service in Loop 2110 - when charged and paid amounts are not equal in SVC
Service Identification	Repeats once for each service detail in Loop 2110
Reference Identification	
Supplemental Amount (Situational)	Medicaid Only
Supplemental Quantity (Situational)	Medicaid Only
Health Care Remark Codes (Situational)	Repeats for each Remark Code generated by Payment System for Service in Loop 2110 - reports service level error codes
E. PROVIDER LEVEL ADJUSTMENT	
Provider Adjustment (Situational)	Occurs as many times as necessary, associated with Loop 1000B Payee - used to report adjustments that are not specific to a particular claim or to report provider accounts payable entries
F. TRANSACTION TRAILER	
Transaction Set Trailer	Must match ST
Functional Group Trailer	Must match GT and ISA
Interchange Control Trailer	

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835 Transaction Layout

HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
INTERCHANGE CONTROL HEADER		**Occurs 1 time**	**Required**
ISA	Interchange Control Header	8	ISA
ISA01	Authorization Information Qualifier.	2/2	00 - No Authorization Info Present
ISA02	Authorization Information	10/10	
ISA03	Security Information. Qualifier	2/2	00 - No Security Info Present
ISA04	Security Information	10/10	
ISA05	Interchange ID Qualifier	2/2	ZZ – Mutually Defined Id for Sender in ISA06
ISA06	Interchange Sender ID.	15/15	NCXIX
ISA07	Interchange ID Qualifier	2/2	ZZ – Mutually Defined Id for Sender in ISA08
ISA08	Interchange Receiver ID	15/15	Sender ID = Number from Trading Partner Agreement
ISA09	Interchange Date	6/6	Date of the Interchange in YYMMDD format
ISA10	Interchange Time	4/4	Time of the Interchange in HHMM format
ISA11	Interchange Control Standard Identification	1/1	U - US EDI Community of ANSI X12 standards
ISA12	Interchange Control Version Number	5/5	00401– Version of above Standards
ISA13	Interchange Control Number	9/9	Number assigned by sender. Must = the number in IEA02
ISA14	Acknowledgment Requested	1/1	0 – No acknowledgement necessary
ISA15	Usage Indicator	1/1	T - Test Data P- Production Data
ISA16	Component Element Separator	1/1	Delimiter used to separate component elements
Example Segment ISA*00* *00* *ZZ*NCXIX*ZZ*123456789 *000901*1705*U*00401*000000001*0*T*:~			
FUNCTIONAL GROUP HEADER		**Occurs 1 time**	**Required**
GS	Functional Group Header	2/2	GS
GS01	Functional Id Code	2/2	HP – 835
GS02	Application Senders Code	15/15	Same number as ISA06 – Identifies the Sender
GS03	Application Receivers Code	15/15	Same number as ISA08 – Identifies the Receiver
GS04	Date	8/8	CCYYMMDD - Group date
GS05	Time	4/8	HHMM - Group time
GS06	Group Control Number	1/9	Control number from sender

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
GS07	Responsible Agency Code	½	X - Accredited Standards Committee
GS08	Version/Release ID Code	1/12	004010X091 - Version of above Standards
Example Segment GS*HP*123456789*NCXIX*20000901*1706*0001*X*004010X091~			
TRANSACTION SET HEADER		**Occurs 1 time**	**Required**
ST	Transaction Set Header	2/2	ST
ST01 - p43	Transaction Set ID Code	3/3	835
ST02 - p43	Transaction Control no.	4/9	Unique no. assigned to transaction set. ST02 and SE02 must be identical.
Example: ST*835*500000001~			
BEGINNING SEGMENT FOR PAYMENT ORDER/REMITTANCE ADVICE		**Occurs 1 time**	**Required**
BPR	Beginning Segment	3/3	BPR
BPR01 - p45	Transaction Heading Code	1/2	Code = H Notification Only – Used for encounter only. Code = I Remittance Info Only
BPR02 - p46	Monetary Amount	1/18	Total Actual Provider Payment Amount – include decimal
BPR03 - p46	Credit/Debit Flag Code	1/1	C – Credit
BPR04 - p46	Payment Method Code	3/3	ACH - Automated Clearing House - used for electronic funds transfer (EFT) BOP – Financial Institution Option CHK – Check FWT – Federal Reserve Fund/ Wire Transfer Use payment method code NON if BPR01 = H.
BPR05 - p47	Payment Format Code	1/10	CCP - Cash Concentration/Disbursement - If BPR04 = ACH
BPR06 - p48	DFI ID Number Qualifier	2/2	01 – ABA Transit Routing Number Including Check Digits
BPR07 - p48	DFI Identification Number	3/12	05311091 – Medicaid 053100494 - IPRS
BPR08 - p48	Account Number Qualifier	1/3	DA – Demand Deposit
BPR09 - p49	Originator's Account Number	1/35	8730096875 – Medicaid 8730010202 - IPRS

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
BPR10 - p49	Originating Company Identifier	10/10	1752548221 – Federal Tax ID proceeded by a '1'.
BPR11 - p49	Not Used		Not Used
BPR12 - p49	DFI ID Number Qualifier	2/2	01 – ABA Transit Routing Number Including Check Digits
BPR13 - p50	DFI Identification Number	3/12	Number of financial institution receiving the transaction.
BPR14 - p50	Account Number Qualifier	1/3	DA – Demand Deposit SG – Savings
BPR15 - p50	Account Number	1/35	Receiver or Provider Account Number.
BPR16 - p50	Date	8/8	Check Issue or EFT Effective Date. Date expressed as CCYYMMDD. If BPR04 is ACH - date money moves from payer and is available to payee. If BPR04 is CHK - check issuance date. If BPR04 is FTW - date that payer anticipates the money to move. If BPR04 is NON - date 835 is created.
BPR17	Not Used		Not Used
BPR18	Not Used		Not Used
BPR19	Not Used		Not Used
BPR20	Not Used		Not Used
BPR21	Not Used		Not Used
Example: BPR*I*500.5*C*ACH*CCP*01*053100494*DA*8730010202*1752548221**01*1234512345*DA*5432154321*20010202~			
Example: BPR*I*1500*C*CHK**********20010201~			
Example: BPR*I*0*C*NON**********20010301~			
REASSOCIATION TRACE NUMBER		**Occurs 1 time**	**Required**
TRN	Trace	3/3	TRN
TRN01- p52	Trace Type Code	1/2	1 – Current Transaction Trace Numbers
TRN02 - p53	Reference Identification	1/30	Check or EFT Trace Number If BPR04= NON, TRN02=NON.
TRN03 - p53	Originating Company Identifier	10/10	1752548221 – Federal Tax ID, proceeded by a '1'

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
			When BPR10 is used, it must be identical to TRN03
TRN04 - p53	Not Used		Not Used
Example: TRN*1*9999999*1752548221~			
Example: TRN*1*NON*1752548221~			
RECEIVER IDENTIFICATION – CLEARING HOUSE IDENTIFICATION SEGMENT		**Occurs 1 time**	**Situational – Used by Medicaid Only**
REF	Reference Identification	3/3	REF
REF01 - p57	Reference Identification Qualifier	2/3	EV – Receiver Identification Number
REF02 - p57	Reference Identification	1/30	Receiver Identifier
REF03 - p57	Not Used		Not Used
REF04 - p53	Not Used		Not Used
Example: REF*EV*1234567890~			
PRODUCTION DATE		**Occurs 1 time**	**Will always be present for IPRS**
DTM	Date/Time Reference	3/3	DTM
DTM01 - p60	Date/Time Qualifier	3/3	405 – Production
DTM02 – 61	Date	8/8	Production Date – expressed as CCYYMMDD
DTM03	Not Used		Not Used
DTM04	Not Used		Not Used
DTM05	Not Used		Not Used
DTM06	Not Used		Not Used
Example: DTM*405*20010102~			
LOOP 1000A – PAYER IDENTIFICATION		**Occurs 1 time**	
Payer Identification		**Occurs 1 time per Loop 1000A occurrence**	**Required**
N1	Name	2/2	N1
N101 - p62	Entity Identifier Code	2/3	PR – Payer
N102 - p63	Name	1/60	NORTH CAROLINA MEDICAID – Medicaid EDS/NC DMH/DD/SA - IPRS
N103 - p63	Not Used		Not Used
N104 - p63	Not Used		Not Used
N105 - p63	Not Used		Not Used
N106 - p63	Not Used		Not Used
Example: N1*PR*EDS/NORTH CAROLINA MEDICAID~			

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
Example: N1*PR*EDS/NC DMH/DD/SA~			
Payer Address		**Occurs 1 time per Loop 1000A occurrence**	**Required**
N3	Address Information	2/2	N3
N301 - p64	Address Information	1/55	PO BOX 30968 - Medicaid PO BOX 300020 – IPRS
N302 - p64	Not Used		Not Used
Example: N3*PO BOX 300020~			
Payer City, State, Zip Code		**Occurs 1 time per Loop 1000A occurrence**	**Required**
N4	Geographic Location	2/2	N4
N401 - p65	City Name	2/30	Raleigh
N402 - p65	State or Province Code	2/2	NC
N403 - p65	Postal Code	3/15	27622
N404 - p65	Not Used		Not Used
N405- p66	Not Used		Not Used
N406 - p66	Not Used		Not Used
Example: N4*RALEIGH*NC*27622~			
LOOP 1000B – PAYEE IDENTIFICATION		**Occurs 1 time**	
Payee Identification		**Occurs 1 time per Loop 1000B occurrence**	**Required**
N1	Name	2/2	N1
N101 - p72	Entity Identifier Code	2/3	PE – Payee
N102 - p73	Name	1/60	Billing Provider's name.
N103 - p73	Identification Code Qualifier	1/2	FI – Federal Taxpayer's Identification Number XX – NPI
N104 - p73	Identification Code	2/80	Taxpayer ID or NPI obtained from IPRS provider database.
N105 - p73	Not Used		Not Used
N106 - p73	Not Used		Not Used
Example: N1*PE*BILLING PROVIDER NAME*FI*12345678~			

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
Payee Address		**Occurs 1 time per Loop 1000B occurrence**	**Will always be present for IPRS**
N3	Address Information	2/2	N3
N301 - p74	Address Information	1/55	Payee Address Line
N302 - p74	Not Used		Not Used
Example: N3*454 MAIN STREET~			
Payee, City, State, Zip Code		**Occurs 1 time per Loop 1000B occurrence**	**Will always be present for IPRS**
N4	Geographic Location	2/2	N4
N401 - p75	City Name	2/30	Payee City Name
N402 - p75	State or Province Code	2/2	Payee State Code
N403 - p75	Postal Code	3/15	Payee Postal Zone or ZIP Code
N404 - p76	Not Used		Not Used
N405- p76	Not Used		Not Used
N406 - p76	Not Used		Not Used
Example: N4*WILMINGTON*NC*22331~			
Payee Additional Identification		**Occurs as many times as needed per Loop 1000B occurrence**	**Will always be present for IPRS**
REF	Reference Identification	3/3	REF
REF01 - p77	Reference Identification Qualifier	2/3	PQ – Payee Identification TJ – Federal Taxpayer's Identification Number
REF02 - p78	Reference Identification	1/30	Additional Payee Identifier. LMA Base Billing Provider ID from claim or Taxpayer ID from Provider database.
REF03 - p78	Not Used		Not Used
REF04 - p78	Not Used		Not Used
Example: REF*PQ*BASE BILLING ID~			

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
LOOP 2000 – HEADER NUMBER		**As many times as necessary per Loop 1000B occurrence**	
Header Number		**One time per Loop 2000 occurrence**	**Will always be present for IPRS**
LX	Assigned Number	2/2	LX
LX01 - p79	Assigned Number	1/6	Sequentially incremented by 1 for each provider.
Example: LX*1~			
Provider Summary Information - Submitted Billing Provider ID in IPRS – Transaction Statistics		**One time per Loop 2000 occurrence**	**Will always be present for IPRS**
TS	Transaction Statistics	2/2	TS
TS301 - p81	Reference Identification	1/30	Submitted Billing Provider ID or NPI (whoever billed the claim).
TS302 - p81	Facility Code Value	1/2	12
TS303 - p81	Date	8/8	Fiscal Period Date expressed as CCYYMMDD. Last day of the provider's fiscal year. If not known, use December 31st of current year.
TS304 - p81	Quantity	1/15	Total Number of Claims Count
TS305 - p82	Monetary Amount	1/18	Total Claim Charge Amount including decimal if cents reported
TS306 - p82	Not Used		Not Used
TS307 - p82	Not Used		Not Used
TS308 - p82	Not Used		Not Used
TS309 - p82	Monetary Amount	1/18	Total Provider Payment Amount No value is reported when there is no provider payment.
TS310 - p82	Not Used		Not Used
TS311 - p82	Not Used		Not Used
TS312 - p83	Not Used		Not Used
TS313 - p83	Not Used		Not Used
TS314 - p83	Not Used		Not Used
TS315 - p82	Not Used		Not Used

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
TS316 - p83	Not Used		Not Used
TS317 - p83	Not Used		Not Used
TS318 - p83	Not Used		Not Used
TS319 - p84	Not Used		Not Used
TS320 - p84	Not Used		Not Used
TS321 - p84	Not Used		Not Used
TS322 - p84	Not Used		Not Used
TS323 - p84	Not Used		Not Used
TS324 - p84	Not Used		Not Used
Example: TS3*12345678*12*20011221*1*500.5****500.5~			
LOOP 2100 – CLAIM PAYMENT INFORMATION		**Occurs as many times as needed per Loop 2000 occurrence**	
Claim Payment Information		**Occurs once per Loop 2100 occurrence**	**Required**
CLP	Claim Level Data	3/3	CLP
CLP01 - p89	Claim Submitter's Identifier	1/38	Patient Control Number assigned by the provider.
CLP02 - p90	Claim Status Code	1/2	1-Processed as Primary 2-Processed as Secondary 3-Processed as Tertiary 4-Denied 19-Processed as Primary, Forwarded to additional Payer (Denied claim that is systematically re-entered to a new Pop Group Payer) 22-claim adjustment
CLP03 - p91	Monetary Amount	1/18	Total Claim Charge Amount
CLP04 - p91	Monetary Amount	1/18	Claim Payment Amount. Amount will be zero (0) if no payment is made.
CLP05 - p91	Patient Responsibility Amount	1/18	Situational – Used by Medicaid - Not Used in IPRS
CLP06 - p92	Claim Filing Indicator Code	1/2	MC – Medicaid or IPRS 13 – Point of Sale HM – HMO
CLP07 - p93	Reference Identification	1/30	Adjudication system generated ICN.
CLP08 - p93	Facility/Place of Service Code	1/2	Place of Service value reported on 837 in CLM05-1 or in

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
	Value		override field SV105. Refer to this reference for list of additional values.
CLP09 - p93	Not Used		Not Used
CLP10 - p93	Not Used		Not Used
CLP11 - p93	Not Used		Not Used
CLP12 - p93	Not Used		Not Used
CLP13 - p94	Not Used		Not Used
Example: CLP*12345678*1*500.5*400.5**MC*252003001000001*99~			
Claim Adjustment		**Occurs up to 99 times per Loop 2100 occurrence**	**Situational – Created only when the sum of the details are not equal to the Header Billed amount**
CAS	Claims Adjustment	3/3	CAS
CAS01 - p97	Claim Adjustment Group Code	1/2	CO – Contractual Obligations CR – Correction and Reversals (CLP02 = 22) OA – Other Adjustments PI - Payor Initiated Reduction (CLP02 not = 22) PR – Patient Responsibility
CAS02 - p97	Claim Adjustment Reason Code	1/5	Header Adjustment Reason Code
CAS03 - p97	Monetary Amount	1/18	Adjustment Amount
CAS04 - p98	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS05 - p98	Claim Adjustment Reason Code	1/5	Claim Adjustment Reason Code – if multiple reasons
CAS06 - p98	Monetary Amount	1/18	Adjustment Amount
CAS07 - p98	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS08 - p98	Claim Adjustment Reason Code	1/5	Claim Adjustment Reason Code – if multiple reasons
CAS09 - p99	Monetary Amount	1/18	Adjustment Amount
CAS10 - p99	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS11 - p99	Claim Adjustment Reason Code	1/5	Claim Adjustment Reason Code – if multiple reasons
CAS12 - p99	Monetary Amount	1/18	Adjustment Amount
CAS13 - p99	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS14 - p100	Claim Adjustment Reason Code	1/5	Claim Adjustment Reason Code – if multiple reasons

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
CAS15 - p100	Monetary Amount	1/18	Adjustment Amount
CAS16 - p100	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS17 - p100	Claim Adjustment Reason Code	1/5	Claim Adjustment Reason Code – if multiple reasons
CAS18 - p100	Monetary Amount	1/18	Adjustment Amount
CAS19 - p101	Quantity	1/15	Adjustment Units – when units are being adjusted
Example: CAS*PI*HEADER REASON CODE 1*100~			
Patient Name		**Occurs 1 time per Loop 2100 occurrence**	**Required**
NM1	Individual Name	3/3	NM1
NM101 - p102	Entity Identifier Code	2/3	QC – Patient
NM102 - p103	Entity Type Qualifier	1/1	1 – Person
NM103 - p102	Name Last or Org Name	1/35	Patient Last Name
NM104 - p104	Name First	1/25	Patient First Name
NM105 - p103	Name Middle	1/25	Patient Middle Name
NM106 - p103	Not Used		Not Used
NM107 - p103	Name Suffix	1/10	Not Used in IPRS
NM108 - p103	Identification Code Qualifier	1/2	MI – Member Identification Number - IPRS MR – Medicaid Recipient Identification Number - Medicaid
NM109 - p104	Identification Code	2/80	Submitted Client ID
NM110 - p104	Not Used		Not Used
NM111 - p104	Not Used		Not Used
Example: NM1*QC*1*LAST NAME*FIRST NAME****MI*12345678901~ FOR IPRS			
Example: NM1*QC*1*LAST NAME*FIRST NAME****MR*123456789A~ FOR MEDICAID			
Service Provider Name -		**Occurs 1 time per Loop 2100 occurrence**	**Situational – Required when Rendering (attending) Provider is not the Payee**
NM1	Individual Name	3/3	NM1
NM101 - p112	Entity Identifier Code	2/3	82 – Rendering (attending) Provider.
NM102 - p112	Entity Type Qualifier	1/1	1 – Person 2 – Non-Person Entity
NM103 - p112	Name Last or Org Name	1/35	Rendering Provider Last or Org Name
NM104 - p112	Name First	1/25	Rendering Provider First Name
NM105 - p112	Name Middle	1/25	Rendering Provider Middle Name
NM106 - p112	Not Used		Not Used

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NM107 - p112	Not Used		Not Used
NM108 - p113	Identification Code Qualifier	1/2	MC – Medicaid Provider Number - Medicaid SL – State License Number – IPRS XX - NPI
NM109 - p113	Identification Code	2/80	Attending Provider Number or NPI
NM110 - p113	Not Used		Not Used
NM111 - p113	Not Used		Not Used
Example: NM1*82*1*PROV LAST NAME*PROV FIRST NAME****MC*MEDICAID PROV NUMBER~ (FOR MEDICAID)			
Example: NM1*82*2*PROV ORG NAME*****SL*IPRS ATTENDING PROVIDER NUMBER~ (FOR IPRS)			
Corrected Priority Payer		**Occurs 2 times per Loop 2100 occurrence**	**Situational – Used by Medicaid ONLY**
NM1	Individual Name	3/3	NM1
NM101 - p116	Entity Identifier Code	2/3	PR – Payer
NM102 - p117	Entity Type Qualifier	1/1	2 – Non-Person Entity
NM103 - p117	Name Last or Org Name	1/35	Corrected Priority Payer Name
NM104 - p117	Not Used		Not Used
NM105 - p117	Not Used		Not Used
NM106 - p117	Not Used		Not Used
NM107 - p117	Not Used		Not Used
NM108 - p117	Identification Code Qualifier	1/2	PI – Payor Identification
NM109 - p117	Identification Code	2/80	Corrected Priority Payer Identification Number
NM110 - p117	Not Used		Not Used
NM111 - p117	Not Used		Not Used
Example: NM1*PR*2*PRIORITY PAYER NAME*****PI*TPL PROV NUMBER~ (FOR MEDICAID)			
Outpatient Adjudication Information		**Occurs 1 time per Loop 2100 occurrence**	**Situational – Used by Medicaid ONLY**
MOA	Medicare Outpatient Adjudication	3/3	MOA
MOA01 – p124	Percent	1/10	Reimbursement Rate expressed as a decimal
MOA02 – p124	Not Used		Not Used
MOA03 - p124	Remark Code	1/30	Remark Code 1
MOA04 - p124	Remark Code	1/30	Remark Code 2 – If multiple remark codes
MOA05 - p124	Remark Code	1/30	Remark Code 3 – If multiple remark codes
MOA06 - p125	Remark Code	1/30	Remark Code 4 - If multiple remark codes

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
MOA07 - p125	Remark Code	1/30	Remark Code 5 - If multiple remark codes
MOA08 - p125	Not Used		Not Used
MOA09 - p125	Not Used		Not Used
Example: MOA*222.22**REMARK 1*REMARK 2~ (FOR MEDICAID)			
Other Claim Related Identification Claim Payment Information (1st Occurrence)		**Occurs up to 5 times per Loop 2100 occurrence**	**Will always be present for MMIS+**
REF	Reference Identification	3/3	REF
REF01 - p126	Reference Identification Qualifier	2/3	EA – Medical Record Identification Number – for MMIS+
REF02 - p127	Reference Identification	1/30	Medical record number
REF03 - p127	Not Used		Not Used
REF04 - p127	Not Used		Not Used
Example: REF*EA*123456789~			
Other Claim Related Identification Claim Payment Information		**(2nd Occurrence)**	**Will always be present for IPRS**
REF	Reference Identification	3/3	REF
REF01 - p126	Reference Identification Qualifier	2/3	1L – Group Number
REF02 - p127	Reference Identification	1/30	CNDS Base ID
REF03 - p127	Not Used		Not Used
REF04 - p127	Not Used		Not Used
Example: REF*1L*123456789A~			
Claim Date (1st Occurrence)		**Occurs up to 4 times per Loop 2100 occurrence**	**Will always be present for IPRS**
DTM	Date/Time Reference	3/3	DTM
DTM01 - p131	Date/Time Qualifier	3/3	232 – Claim Period Start Date
DTM02 - p131	Date	8/8	Claim Date expressed as CCYYMMDD
DTM03 - p131	Not Used		Not Used
DTM04 - p131	Not Used		Not Used
DTM05 - p131	Not Used		Not Used
DTM06 - p131	Not Used		Not Used
Example: DTM*232*20010101~			

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
Claim Date		**(2nd Occurrence)**	**Will always be present for IPRS**
DTM	Date/Time Reference	3/3	DTM
DTM01 - p131	Date/Time Qualifier	3/3	233 – Claim Period End Date
DTM02 - p131	Date	8/8	Claim Date expressed as CCYYMMDD.
DTM03 - p131	Not Used		Not Used
DTM04 - p131	Not Used		Not Used
DTM05 - p131	Not Used		Not Used
DTM06 - p131	Not Used		Not Used
Example: DTM*233*20010201~			
Claim Supplemental Information Quantity		**Occurs up to 14 times per Loop 2100 occurrence**	**NOT USED UNDER HIPAA COMPLIANCY**
QTY	Quantity	3/3	**Not Used**
QTY01 - p138	Quantity Qualifier	2/2	**Not Used**
QTY02 - p138	Quantity	1/15	**Not Used**
QTY03 – p138	Not Used		**Not Used**
QTY04 – p138	Not Used		**Not Used**
Example: QTY*OU*30~			
LOOP 2110 - SERVICE PAYMENT INFORMATION		**Occurs up to 999 times per Loop 2100 occurrence**	
Service Payment Information		**Occurs 1 time per Loop 2110 occurrence**	**Will always be present for IPRS**
SVC	Service Information	3/3	SVC
SVC01 - p140	Composite Medical Procedure Identifier		
SVC01-1 - p140	Product/Service ID Qualifier	2/2	HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes See Implementation Guide p140-141 for additional values.
SVC01-2 - p141	Product/Service ID	1/48	Procedure Code
SVC01-3 - p141	Procedure Modifier - 1	2/2	Modifier 1 – if applicable
SVC01-4 - p141	Procedure Modifier - 2	2/2	Modifier 2 – if applicable

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
SVC01-5 - p141	Procedure Modifier – 3	2/2	Modifier 3 – if applicable
SVC01-6 - p141	Procedure Modifier - 4	2/2	Modifier 4 – if applicable
SVC01-7 - p141	Not Used		Not Used
SVC02 - p142	Monetary Amount	1/18	Claim detail charge amount
SVC03 - p142	Monetary Amount	1/18	Claim detail paid amount
SVC04 - p142	Not Used		Not Used
SVC05 - p142	Quantity	1/15	Use this number for the paid units of service. If not present, the valued is assumed to be one. When a claim is denied, this will be the negative value of units submitted to indicate a refusal of paid units.
SVC06 - p143	Composite Medical Procedure Identifier		Not Used
SVC06 – 1 - p143	Not Used		Not Used
SVC06 – 2 - p144	Not Used		Not Used
SVC06 – 3 - p144	Not Used		Not Used
SVC06 – 4 - p144	Not Used		Not Used
SVC06 – 5 - p144	Not Used		Not Used
SVC06 – 6 - p144	Not Used		Not Used
SVC06 – 7 - p144	Not Used		Not Used
SVC07 - p145	Quantity	1/15	This is required only when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. Number of units billed if number of units paid is more or less than units billed.
Example: SVC*HC:ADJUDICATED PROCEDURE:ADJUDICATED MOD1*50.5*50.5**5*HC:SUBMITTED PROCEDURE:SUBMITTED MOD1~			
Service Date (1st Occurrence)		**Occurs Up to 3 times per Loop 2110 occurrence**	**Will always be present for IPRS**
DTM	Date/Time Reference	3/3	DTM
DTM01 - p147	Date/Time Qualifier	3/3	150 – Service Period Start when different from Period End 472 – When Period Start same as Period End
DTM02 - p147	Date	8/8	Service Date expressed as CCYYMMDD
DTM03 - p147	Not Used		Not Used
DTM04 - p147	Not Used		Not Used

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
DTM05 - p147	Not Used		Not Used
DTM06 - p147	Not Used		Not Used
Example: DTM*150*20010101~			
Example: DTM*472*20010101~			
Service Date		**(2nd Occurrence)**	**Situational – Required only when Occurrence 1 DTM01 = 150**
DTM	Date/Time Reference	3/3	DTM
DTM01 - p147	Date/Time Qualifier	3/3	151 – Service Period End
DTM02 - p147	Date	8/8	Service Date expressed as CCYYMMDD
DTM03 - p147	Not Used		Not Used
DTM04 - p147	Not Used		Not Used
DTM05 - p147	Not Used		Not Used
DTM06 - p147	Not Used		Not Used
Example: DTM*151*20010201~			
Service Adjustment		**Occurs up to 99 times per Loop 2110 occurrence**	**Situational – Not created if Paid and Charged amounts (SVC02/SVC03) are equal**
CAS	Claims Adjustment	3/3	CAS
CAS01 - p150	Claim Adjustment Group Code	1/2	CO – Contractual Obligations CR – Correction and Reversals (CLP02 = 22) OA – Other Adjustments PI - Payor Initiated Reduction (CLP02 not = 22) PR – Patient Responsibility
CAS02 - p150	Claim Adjustment Reason Code	1/5	Detail Adjustment Reason Code
CAS03 - p150	Monetary Amount	1/18	Adjustment Amount
CAS04 - p150	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS05 - p151	Claim Adjustment Reason Code	1/5	Detail Adjustment Reason Code – if multiple reasons
CAS06 - p151	Monetary Amount	1/18	Adjustment Amount
CAS07 - p151	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS08 - p151	Claim Adjustment Reason Code	1/5	Detail Adjustment Reason Code – if multiple reasons
CAS09 - p151	Monetary Amount	1/18	Adjustment Amount
CAS10 - p152	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS11 - p152	Claim Adjustment Reason	1/5	Detail Adjustment Reason Code – if multiple reasons

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	Code		
CAS12 - p152	Monetary Amount	1/18	Adjustment Amount
CAS13 - p152	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS14 - p152	Claim Adjustment Reason Code	1/5	Detail Adjustment Reason Code – if multiple reasons
CAS15 - p153	Monetary Amount	1/18	Adjustment Amount
CAS16 - p153	Quantity	1/15	Adjustment Units – when units are being adjusted
CAS17 - p153	Claim Adjustment Reason Code	1/5	Detail Adjustment Reason Code – if multiple reasons
CAS18 - p153	Monetary Amount	1/18	Adjustment Amount
CAS19 - p153	Quantity	1/15	Adjustment Units – when units are being adjusted
Example: CAS*PI* DETAIL REASON CODE 1*25*5~			
Reference Identification (1st Occurrence)		**Occurs up to 7 times per Loop 2110 occurrence**	**Will always be present for IPRS**
REF	Reference Identification	3/3	REF
REF01 - p154	Reference Identification Qualifier	2/3	6R – Provider Control Number
REF02 - p155	Reference Identification	1/30	Originating system detail line item control number.
REF03 - p155	Not Used		Not Used
REF04 - p155	Not Used		Not Used
Example: REF*6R*123456789~			
Reference Identification		**(2nd Occurrence)**	**Will always be present for IPRS**
REF	Reference Identification	3/3	REF
REF01 - p154	Reference Identification Qualifier	2/3	Code = LU Location Number
REF02 - p155	Reference Identification	1/30	Population Group Payer
REF03 - p155	Not Used		Not Used
REF04 - p155	Not Used		Not Used
Example: REF*LU*POP GROUP PAYER~			
Reference Identification		**(3rd Occurrence)**	**Will always be present for IPRS**
REF	Reference Identification	3/3	REF
REF01 - p154, 156	Reference Identification Qualifier	2/3	Code = RB Rate Code Number HPI – HCFA NPI

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
REF02 - p155, 157	Reference Identification	1/30	Agency Location Number or NPI
REF03 - p155, 157	Not Used		Not Used
REF04 - p155, 157	Not Used		Not Used
Example: REF*RB*DS00001P~			
Reference Identification		**(4th Occurrence)**	**Situational – Present when Rendering (attending) Provider is specific to the Detail Level**
REF			
REF01 - p156	Reference Identification Qualifier	2/3	1J – Facility ID Number – IPRS 1D – Medicaid Provider Number
REF02 - p157	Rendering Provider Identifier	1/30	Rendering Provider ID
REF03 - p157	Not Used		Not Used
REF04 - p157	Not Used		Not Used
Example: REF*1J*DS00025~ (For IPRS)			
Example: REF*1D*3404999~ (For MEDICAID)			
Service Payment Information		**Occurs up to 12 times per Loop 2110 occurrence**	**Situational - Used by Medicaid Only**
AMT	Service Supplemental Amount	1/3	AMT
AMT01 - p158	Amount Qualifier Code	1/3	B6 – Allowed - Actual
AMT02 - p159	Monetary amount	1/18	Supplemental amount
AMT03 - p159	Not Used		Not Used
Example: AMT*B6*100.00~			
Service Payment Information		**Occurs up to 6 times per Loop 2110 occurrence**	**Situational - Used by Medicaid Only**
QTY	Service Supplemental Quantity	1/3	QTY
QTY01 - p160	Quantity Qualifier Code	2/2	NE – Non-Covered Visits
QTY02 - p161	Quantity	1/15	Supplemental quantity count
QTY03 - p161	Not Used		Not Used
QTY04 - p161	Not Used		Not Used
Example: QTY*NE*5~			
Health Care Remark Codes		**Occurs up to 99 times per Loop 2110 occurrence**	**Situational – Used to report error codes if any exist**

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
LQ	Industry Code	2/2	LQ
LQ01 - p162	Code List Qualifier Code	1/3	HE – Claim Payment Remark Codes RX – National Council for Prescription Drug Program – Reject/Payment Codes
LQ02 - p163	Industry Code	1/30	Used to report Remark Codes
Example: LQ*HE*REMARK CODE~			
PROVIDER ADJUSTMENT		**Occurs as many times as necessary**	**Situational – Used to report adjustments that are not specific to a particular claim or balancing entries due to provider accounts payable processing (accounts receivables collected by the State)**
PLB	Provider Level Adjustment	3/3	PLB
PLB01 - p165	Reference Identification	1/30	IPRS Base Provider Number.
PLB02 - p165	Date	8/8	Fiscal Period Date expressed as CCYYMMDD Last day of the provider's fiscal year. If unknown, use Dec 31st of current year.
PLB03 - p165	Adjustment Identifier		
PLB03 – 1 p165	Adjustment Reason Code	2/2	Reason codes begin on page 165 of implementation guide.
PLB03 – 2 p170	Reference Identification	1/30	Cash Control Number.
PLB04 - p170	Monetary Amount	1/18	Provider Adjustment Amount
PLB05 - p170	Adjustment Identifier		
PLB05 – 1 p170	Adjustment Reason Code	2/2	Code indicating reason for adjustment – if multiple reasons
PLB05 – 2 p170	Reference Identification	1/30	Provider Adjustment Identifier
PLB06 - p170	Monetary Amount	1/18	Provider Adjustment Amount
PLB07 - p171	Adjustment Identifier		
PLB07 – 1 p171	Adjustment Reason Code	2/2	Code indicating reason for adjustment – if multiple reasons
PLB07 – 2 p171	Reference Identification	1/30	Provider Adjustment Identifier
PLB08 - p171	Monetary Amount	1/18	Provider Adjustment Amount
PLB09 - p171	Adjustment Identifier		
PLB09- 1 p171	Adjustment Reason Code	2/2	Code indicating reason for adjustment – if multiple reasons
PLB09 – 2 p171	Reference Identification	1/30	Provider Adjustment Identifier
PLB10 - p171	Monetary Amount	1/18	Provider Adjustment Amount
PLB11- p171	Adjustment Identifier		
PLB11 – 1 p171	Adjustment Reason Code	2/2	Code indicating reason for adjustment – if multiple reasons
PLB11 – 2 p172	Reference Identification	1/30	Provider Adjustment Identifier
PLB12- p172	Monetary Amount	1/18	Provider Adjustment Amount
PLB13- p172	Adjustment Identifier		

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HIPAA FIELD – PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT
PLB13 – 1 p172	Adjustment Reason Code	2/2	Code indicating reason for adjustment – if multiple reasons
PLB13 – 2 p172	Reference Identification	1/30	Provider Adjustment Identifier
PLB14 - p172	Monetary Amount	1/18	Provider Adjustment Amount
Example: PLB*IPRS BASE PROV NUMBER*20011231*REASON CODE:PAYER'S CCN*ADJUSTMENT AMOUNT~			
TRANSACTION SET TRAILER		**Occurs 1 time**	**Required**
SE	Transaction Set Trailer	2/2	SE
SE01 - p173	Number of Included Segments	1/10	Transaction Segment Count
SE02 - p173	Transaction Set Control Number	4/9	Transaction Set Control Number Numbers in ST02 and SE02 must be identical.
Example: SE*1*500000001~			
FUNCTIONAL GROUP TRAILER		**Occurs 1 time**	**Required**
GE	Interchange Control Header	3/3	GE
GE01	Number of Transaction Sets	2/2	Number of Transaction Sets (ST - SE)
GE02	Group Control Number	10/10	Must =- GS06
Example of Segment GE*1*0001~			
INTERCHANGE CONTROL TRAILER		**Occurs 1 time**	**Required**
IEA	Interchange Control Header	3/3	IEA
IEA01	Number of Included Functional Groups	1/5	Number of function groups (GS - GE)
IEA02	Interchange Control Number	9/9	Must = ISA13
Example of Segment IEA*1*000000001~			

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Balancing

The amounts reported in the 835, if present, must balance at three different levels: the service line, the claim, and the transaction. Adjustments within the 835, through use of the Claim Adjustment and Service Adjustment Segments, CAS, or Provider Adjustment Segments, PLB, decrease the payment when the adjustment amount is positive, and increase the payment when the adjustment amount is negative.

Service Line Balancing

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2110 SERVICE PAYMENT INFORMATION			999
070	SVC	Service Payment Information	S	1	
...					
090	CAS	Service Adjustment	S	99	
...					

Although the service payment information is optional, it is required for all professional claims or anytime payment adjustments are related to specific line items from the original submitted claim. When used, the submitted service charge minus the sum of all monetary adjustments must equal the amount paid for this service line.

Example:

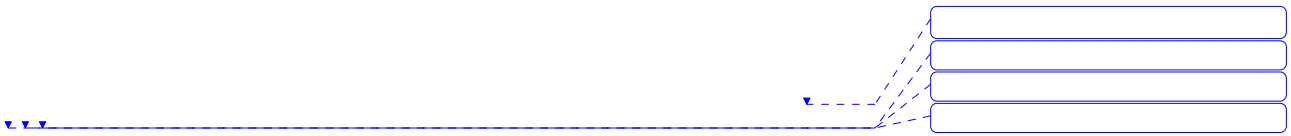
Amount 1 - Amount 2 = Amount 3
Where:

Amount 1 — transmitted in the Service Payment Information Segment, SVC02 - is the submitted charge for this service.

Amount 2 — transmitted in the Service Adjustment Segment, the sum of CAS03, 06, 09, 12, 15, and 18 — is the monetary adjustment amount applied to this service.

Amount 3 — transmitted in the Service Payment Information Segment, SVC03 — is the paid amount for this service.

Special Considerations



Balancing (continued)

Claim Balancing

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			>1
010	CLP	Claim Payment Information	R	1	
020	CAS	Claim Adjustment	S	99	
...					
		LOOP ID - 2110 SERVICE PAYMENT INFORMATION			999
070	SVC	Service Payment Information	S	1	
...					
090	CAS	Service Adjustment	S	99	

Balancing must occur within each Claim Payment loop so that the submitted charges for the claim minus the sum of all monetary adjustments equals the claim paid amount.

When the Service Payment Information loop is present, the following formula applies:

Example:

Amount 4 - Amount 5 = Amount 6
Where:

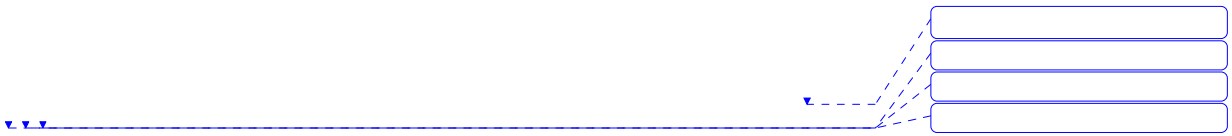
Amount 4 — transmitted in the Claim Payment Segment, CLP03 — is the total submitted charge for the claim.

Amount 5 — transmitted in the Claim Adjustment Segment and/or Service Adjustment Segment, the sum of CAS03, 06, 09, 12, 15, and 18 — is the monetary adjustment amount applied to this claim.

Amount 6 — transmitted in the Claim Payment Segment, CLP04 — is the paid amount for this claim.

Special Considerations

- Adjustments within the Claim Adjustment or Service Adjustment Segments decrease the payment when the adjustment amount is positive and increase the payment when the



Balancing (continued)

Transaction Balancing

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
020	BPR	Financial Information	R	1	
...					

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			>1
010	CLP	Claim Payment Information	R	1	
...					

Table 3 - Summary

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	PLB	Provider Adjustment	S	>1	

Within the transaction, the sum of all claim payments minus the sum of all provider level adjustments equals the total payment amount.

Example:

Amount 7 - Amount 8 = Amount 9
Where:

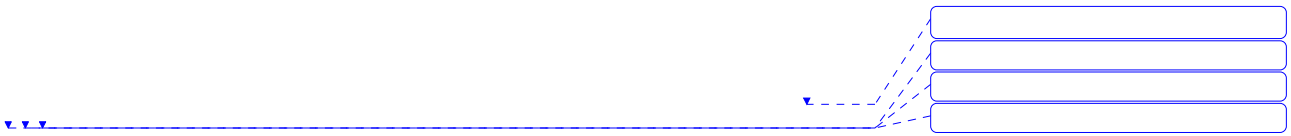
Amount 7 — the sum of all CLP04 amounts transmitted in the Claim Payment Segment — is the total of all claim amounts included in this transaction set.

Amount 8 — the sum of PLB04, 06, 08, 10, 12, and 14 transmitted in the Provider Adjustments Segment — is the provider level adjustment made to the claim payment.

Amount 9 — transmitted in the Financial Information Segment, BPR02 — is the total payment amount of this claim payment.

Special Considerations

- A positive amount in PLB indicates a decrease in the payment amount. A negative amount in PLB indicates an increase in the payment amount.



Balancing (continued)

Remittance Tracking

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
040	TRN	Reassociation Trace Number	R	1	
...					

The Reassociation Key Segment, TRN, contains a trace number for the transaction set. Trace Number, TRN02, which is used to reassociate payments and remittances sent separately, should be a unique number.

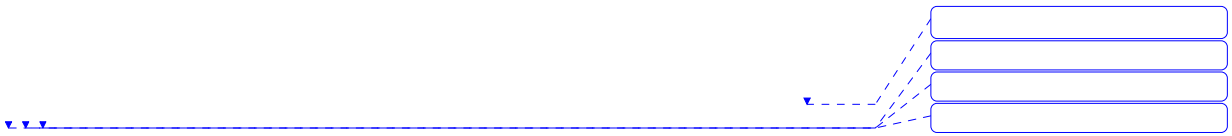
- For check payments, TRN02 is the check number.
- For Electronic Funds Transfer (EFT) payments, TRN02 is the unique number assigned by the payer to identify this EFT.
- For non-payment transactions, TRN02 is a unique number generated by the transaction set originator as that 835's identification number (e.g., a control number plus a suffix).

In addition, TRN03 is the payer's identification number. TRN03 allows the payee to avoid matching problems in case multiple payers use the same number in TRN02.

Reassociation of Dollars and Data

The 835 is capable of sending health care claim payment remittance data with or without the dollars represented by the data. It is important to facilitate re-association when the remittance data is sent separately from the monetary amounts. Re-association requires that both remittance and monetary data contain information that allows a system to match the items received. The billing provider along with their software vendor should have a method to ensure that payment and remittance advice is reconciled in the patient accounting/accounts receivable system.

835	Description	837
2300 Loop REF02	Detail Line Item Control Number	2400 Loop REF02
2100 Loop CLP01	Internal Patient Account Number	2100 Loop CLM01
TRN02	Links ERA to EFT amount	N/A



Balancing (continued)

Claim Adjustment and Service Adjustment

Table 2 - Detail

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
...					
		LOOP ID - 2100 CLAIM PAYMENT INFORMATION			>1
...					
020	CAS	Claim Adjustment	S	99	
...					
		SERVICE PAYMENT INFORMATION			999
...					
090	CAS	Service Adjustment	S	99	

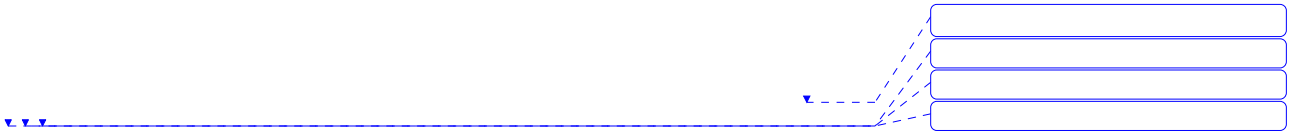
The Claim Adjustment and Service Adjustment Segments provide the reasons, amounts, and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s). The summation of the adjustments at the claim and service levels is the total adjustment for the entire claim. Service level adjustments are not repeated at the claim level.

Under HIPAA guidelines a standardized list of claim adjustment reason codes is used in the Claim Adjustment and Service Adjustment Segments. IPRS will continue to use the ESC and EOB codes similar to those currently used by Medicaid. These codes can be found in this manual, Section 4g: ESC/EOB codes, or on screen through Report2Web. These codes provide the “explanation” for the positive or negative financial adjustments specific to particular claims or services that are referenced in the transmitted 835. Other financial adjustments can be expressed in the Provider Adjustments Segment; however, the claim adjustment reason code list is not used for provider level adjustments.

The Claim Adjustment Group Code, CAS01, categorizes the adjustment reason codes that are contained in a particular CAS.

At either position — the claim level or the service level — each CAS can report up to six different adjustments related to a particular Claim Adjustment Group. This can be seen by noting the re-occurrence of the Claim Adjustment Reason, Monetary Amount, and Quantity data elements, referred to as “an adjustment trio,” in the CAS. There is no specific order to any particular kind of adjustment and an adjustment data element trio. For example, a co-insurance adjustment does not belong at any specific position in the segment. The assumption is that no adjustment trio is used if no meaningful data is included. The first adjustment is placed at the first trio — CAS02, 03, and 04.

If the trio is blank, no adjustments will follow.



Electronic Fund Transfers

All payments made to IPRS billing providers will be made using Electronic Funds Transfers. During the Pilot test, the DHHS Controllers Office will make the payments to the two area program pilot sites, based on payment information provided after each checkwrite cycle.

After the pilot development contract is over, and the contract for ongoing operations is in effect, the Fiscal Agent will make EFT payments to participating IPRS billing providers.

ERA Special Considerations

Printing and Viewing the ERA

In the format that is received by billing providers, the Electronic RA is not easily readable. It consists of a series of complex 'segments' identified by three digit codes, with each piece of information imbedded between asterisks. It is a report not easily understood in the format that it is received.

It is the responsibility of each billing provider to convert the ERA into a printable/ viewable format. This can be accomplished with the assistance of the client accounting software vendor, the use of special e-commerce software packages called 'translators', or through the use of a clearinghouse.

Posting the ERA

One of the most significant potential benefits of an Electronic Remittance Advice is the ability to electronically post claims to the client accounting system. 'Keys' to link the claim to the local client accounting system are included on the electronic claim that is filed by the billing provider. These same 'keys' are included on the Electronic Remittance Advice, so that the client accounting system can post the payment to the correct item in the correct client's account.

It is the responsibility of the billing provider to develop the capability for electronically posting paid claims. This capability has to be built in to the client accounting system by the software vendor.

There are a number of special challenges presented by the MMIS+ with regard to electronic posting:

- When the claim is filed, the billing provider does not know whether the claim will be routed to Medicaid or IPRS.
- Since IPRS pays without regard to other first and third party payments, IPRS could pay an amount larger than the outstanding balance for a service event (client accounting system 'open item'). The client accounting system will have to accommodate 'over-posting.'
- IPRS claims may take multiple cycles to fully process, due to the suspend and 'deny/re-enter'